DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Harbor Chase

DATE SURVEY COMPLETED: February 21, 2022

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from February 15, 2022 through February 21, 2022. The survey process included observations, interviews, review of resident clinical records, facility documents and facility policies and procedures. The facility census on the entrance day of the survey was 87 residents. The survey sample included three residents. Abbreviations/definitions used in this state report are as follows: ED – Executive Director; DRC – Director of Resident Care; LPN – Licensed Practical Nurse; NP – Nurse Practitioner; RN – Registered Nurse; RCP – Resident Care Partner; Level of care 4 – facility level of care needed by the resident (1- 4). Four requires transfer assistance. POA (Power of Attorney) – someone appointed to make decisions on your behalf; Service Plan – A document based on the UAI that describes the care needed by the resident. UAI (Uniform Assessment Instrument) – an assessment form used to collect information about the physical condition, medical status and psychosocial needs of an applicant/resident in order to determine eligibility for an assisted living facility.	a) Resident R1 is not in the facility. There will not be an opportunity to update R1 service plan b) In the Assisted Living unit an audit will be conducted to identify residents' service plans that have not have not been updated within 10days of the current UAI (uniform assessment instrument) document. The service plans will be updated according to outcomes of audit.	
3225.0	**Regulations for Assisted Living Facilities**		
3225.13.0	**Service Agreements**	c) It was determined that a registered nurse did not complete a service	

Provider's Signature Ruth Ann Brown, LNHA Title Executive Director Date 3/16/2022

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3225.13.6	**The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** Based on record review and interview, it was determined that for one (R1) out of three residents sampled, the facility failed to complete service agreements in conjunction with the UAI assessment. Findings include: Review of R1's clinical record revealed: 1/28/21 – R1's most recent service plan was completed. 8/4/21 – An annual UAI assessment was completed for R1. Review of facility documentation lacked an additional service agreement completed in conjunction with R1's most recent assessment that was completed on 8/4/21. 2/22/22 4:13 PM– E2 (DRC) confirmed the findings via email. These findings were reviewed with E2 (DRC) on 2/23/22 via email.	plan within the10 day requirement. The registered nursing staff will be in-serviced on the current policies and procedures for updating service plans with in ten days of the completion of a resident's UAI. The RCD (resident care director) or designee will implement a tacking tool to ensure that the service plan is completed within ten days after the completion of the UAI. A monthly audit will be conducted by the RCD or designee for 30% of the current month's UAI and Service Plans for compliance x 4months. Deficiencies will be immediately corrected. Policy and procedure have been reviewed and no changes were necessary to achieve regulatory compliance. d) The NHA/designee will review the outcomes from the RSD monthly audits for compliance and make correction immediately as needed, The NHA review outcome from the compliance audits /monthly during the monthly QAPI meetings for further review until compliance is at 100%. The frequency of the audits will be adjusted according to outcomes.	4/11/2022 End 3225.13.6
3225.19.0	**Records and Reports**		
3225.19.6	**Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**	a) R1 does not reside in the facility. The resident was not affected by this this practice. b) An audit has been completed by the NHA/designee of all the past reportable from the completion date of the	

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	Based on record review and interview, it was determined that the facility failed to immediately report a fall with injury within 8 hours of the occurrence for one (R1) out of three residents reviewed. The facility reported the incident to the State Agency 22 hours later. Findings include: Review of R1's clinical record revealed: 12/20/21 7:14 PM - An x-ray report concluding that R1 had a broken hip was received by the facility. 12/21/21 5:00 PM - The facility reported the incident to the State Agency 22 hours later. During an interview on 2/21/22 at 3:10 PM, just prior to exit, E2 (DRC) confirmed the delay in reporting. Findings were reviewed during the exit conference on 2/21/22 at 3:15 PM with E1 (ED) AND E2 (DRC).	survey February 21, 2022, till 3/16/2022. All reports to the state were in compliance per regulatory guidelines. c) It was determined that some of the professional nurses have not been trained on how to report an incident to the state electronically in the require time per regulation. All professional nursing staff will be trained by the RCD/designee on how to report incidents appropriately via the state website for reportables in the time required by the State. The current incidents will be reviewed weekly by the RCD/designee for compliance. Policy and procedure have been reviewed and no changes were necessary to achieve regulatory compliance. d) The NHA/designee will review all incident reports in conjunction with the state reportable forms for compliance in the current month until a hundred 100% compliance is achieved. Any discrepancies will be noted, staff member will be counselled to improve compliance. Findings will be reported in the monthly QAPI meeting for review and recommendations. The frequency of the audits will be adjusted according to outcomes.	4/11/2022 End 3225.19.6
16 Del. Code, Ch. 11 Sub-Chapter III §1131	**Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients.** **Definitions** **(11) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing meals, and safety.** **This requirement was not met as evidenced by:**	a) Resident R1 is no longer I the community.	

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	Based on record review, interviews, and review of other pertinent documentation as indicated, it was determined that for one (R1) out of three residents reviewed, the facility neglected to ensure attention to the needs of the resident when R1 experienced a fall that resulted in a broken hip. Findings include: The facility policy on falls, undated, directed staff to "After a fall, review the situation and determine if emergency services are needed. Observe the resident for signs of injury and check the following: vital signs, consciousness, evidence of injury, body parts obviously out of proper position/alignment, broken skin, swelling, pain, inability to move, bleeding, open wounds. Provide immediate first aid and calm the resident. Immobilize the resident if injury noted; otherwise assist to bed or chair. Notify physician and if needed emergency services. Notify the residents family and or legal representative. Document the fall in the resident's record. Communicate any resident care changes." The facility job description for LPN's, implemented 11/2016, listed the essential functions of an LPN as: -Assesses and provides resident and family/care giver information pertinent to diagnosis or plan of care. -Prepares incident/accident reports for residents as needed per policy. Notifies the physician and family post incident/accident per policy and documents appropriately. -Recognizes emergencies and life-threatening situations and initiates appropriate actions.	b) An audit will be completed for residents currently on hospice in the assisted living unit by the RCD to ensure orders are being followed in a timely manner. c) It was determined that some of the professional nurses do not document or make copies of communications from hospice. All professional nursing staff will be in-serviced on communicating with hospice related to resident orders and to time date the communication to ensure orders have been completed in a timely manner. Policy and procedure have been reviewed and no changes were necessary to achieve regulatory compliance. D) The RCD will conduct a weekly audit x4weeks then monthly on the timeliness of received medical orders from hospice to ensure they completed in a timely manner. Finding will be reported in the Monthly QAPI meeting for review and recommendations The frequency of the audits will be adjusted according to outcomes.	4/11/2022 End 16 code, CH 11 Sub Chapter 111 1131

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	Review of R1's clinical record revealed: 8/9/19 – R1 was admitted to the facility with a past history of having both hips replaced. R1's advanced healthcare directive, dated 6/30/07, listed both FM1 and FM2 as POA. R1's facility face sheet documented both FM1 and FM2 as sharing POA for R1. 1/28/21 – R1's Service Plan documented the resident was not independent for mobility and used a walker. R1 had more than one fall in the last three months and a notation that "Resident has emergency pendant" and a care level of "4". 8/4/21 – An annual UAI assessment completed for R1 documented the resident as oriented to person, place and time with no memory problems. R1 needed observation/standby assistance with transfers during toileting, "Should have help but often does this herself. Educated on safety and use of pendant on assessment." Transfers self. Emergency response, independent or with assistive device. Fall risk assessment identified conditions that may increase residents' risk of falling, gait problem, impaired balance, fell in last 31-180 days. 12/17/21 – A facility incident report written by E6 (LPN) documented, "At 7:00 PM FM1 and FM3 found resident sitting on the floor. R1 stated that 'I don't know what happened.' This writer assessed resident and found a skin tear to the left elbow." The "injury" section documented the skin tear. The physician notified section documented "hospice", the same time E3 (hospice RN) was notified. No physician name was docu-		

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	mented. The accompanying risk management report documented FM2 as the responsible party notified, and that "FM1 and E8 (RCP) found the resident sitting on the floor. Resident complained of hip pain... This nurse assessed resident and discovered skin tear and obtained a treatment order from hospice." The incident report and accompanying documentation did not document assessment for injury related to the fall such as inability to move limbs, unusual position of limbs or other areas of the body, pain to a specific body part with movement, or immobilization of the resident due to possible injury. 12/17/21 9:37 PM– E6 (LPN) placed a call to hospice and reported R1's fall to the on-call service. 12/17/21 untimed– E3 (hospice RN) documented on a note, "On arrival patient is in bed resting comfortably. Arousable to voice. Alert and oriented...with periods of confusion. Denies pain. Clean, dry, intact dressing [to] the left forearm. Bed in low locked position... Reviewed fall precautions with facility staff. Instructed facility staff to call hospice with any questions or concerns". E3's note did not document an assessment for injury related to the fall as above. 12/18/21 untimed- E3 (hospice RN) documented in a note, "On arrival patient is sitting in wheelchair... alert and oriented...with periods of confusion. Required full assistance with standing and pivoting back to bed reported 10/10 right hip pain. Instructed facility staff to administer pain medication. Patient is able to bend the leg at the knee. Range of motion completed on		

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	right leg. Patient reports pain afterwards. Spoke with daughter with an update. Daughter does not want resident sent to an emergency room. Instructed daughter to call hospice with any questions or concerns." There were no documented instructions for immobilization of the resident due to possible injury. 12/19/21- R1's clinical record lacked evidence of a note or assessment documented by a nurse. 12/20/21 – A note in R1's clinical record documented, "Assessed resident this morning. Nurse aide reported resident with severe pain. Resident presented with external [unusual outward] rotation to the right foot. Attempted to lift right leg at this time resident stiffened up and complained of pain. E5 (NP) notified, new orders for x-ray of hip to be done today. Daughter called and is aware an x-ray will be done today." 12/20/21 untimed – E4 (hospice RN) documented in a note, "Patient received resting in bed. Complaint of pain in right hip. Facility staff states Mobilex has not arrived yet to complete x-ray. Patient was medicated at 11:30 [AM/PM unknown] with morphine. Nurse states medication... effective. Visit with patient stating no pain if she does not move. Attempted to move and yelled out in pain. This nurse provided incontinence care with careful turning. Placed cloth pad below for assist with transfers...conversations with family, patient, and E5 (NP). Check x-ray and manage pain for now." 12/20/21 4:31 PM – E5 (NP) documented a visit to R1 to follow up on chronic medical problems and fall assessment after a fall.		

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	Patient seen and examined at the bedside today. Patient with complaint of right hip and unable to perform ADL's (activities of daily living such as walking and toileting) or get out of bed related to the severity of the right hip pain. Pt stated wanting an x-ray to see what was wrong." 12/20/21- An order was written for R1 to have an x-ray of the right hip pain post (after) fall. Results of the x-ray were sent to the facility the same day at 7:10 PM and concluded a broken right hip. During an interview on 2/18/22 at 2:23 PM with E6 (LPN), E6 stated, "I don't recall much about the incident, whatever is there in the incident report is what was done." E6 then called the Surveyor again at 3:38 PM and stated, "R1 was on the floor, FM1, FM3 and R8 (RCP) were present and told me R1 fell. R1 had pain in the hip. I gave pain medication. The family did not want R1 sent to the hospital. I took vital signs and asked about pain. I got R1 cleaned up and put to bed." When asked if any additional assessment was done, such as injury and whether any immobilization precautions were put into place, E6 stated "I notified hospice to do that. Then FM2 the family on the chart but not the physician because we are to call hospice and they do the rest." E6 was unable to recall if R1 had on an alert pendant and whether the family asked for an x-ray to be completed at the facility. During an interview on 2/18/22 at 1:49 PM, E5 (NP) confirmed being made aware of R1's fall on 12/20/21 and that a visit was made that day that resulted in E5 ordering an x-ray for R1. E5 stated that FM2 was "My		

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	point of contact, when I called FM2 was adamant not to send R1 to the hospital." E5 did not confirm that FM2 refused an x-ray and stated, "They were resistant to a lot." During an interview on 2/21/22 at 1:43 PM with E2 (DRC) it was reported that all nursing staff was familiar with ordering x-rays using Mobilex and that the facility does not do monitoring for wearing of alert pendants. E2 reported x-rays were ordered "As needed if there's a fall and we suspect an injury, in R1's case the family didn't want her to go out." E2 was asked "Whether the family requested an x-ray at the facility?" E2 responded, "It was one person making the decisions. E5 (NP) can tell you, they [FM1 and FM2] weren't on the same page." FM1 and FM2 are listed as shared POA in R1's clinical record. During an interview on 2/21/22 at 2:38 PM, E4 (hospice RN) reported speaking with FM1 and FM2 "After the weekend" that R1 fell. E4 stated, "The decision was not to send R1 to the hospital. I think one of our nurses could see that it looked like a fracture, the foot was turned out and R1 was having some pain, so I think that the x-ray occurred, and the results came, I think that [x-ray] was done over the weekend." During an interview on 2/21/22 at 2:58 PM, E8 (RCP) confirmed that FM1 found R1 on the floor, incontinent of bowel, without the alert pendant. E8 stated, "Towards evening or late afternoon, I was the medication tech. R1 left the dining room and later E8 was told by FM1 that R1 was sitting on the floor. R1 didn't have an alert pendant on, we found the pendant hanging near the bed somewhere. I went and got E6 (LPN)... R1		

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	said "ouuuhh my hip hurts." E8 confirmed being present during E6's (LPN) assessment of R1. E8 stated, I was there when our nurse was there, E6 did vital signs and asked about pain and asked did they want R1 sent out, they said no." E8 confirmed during her time in the room, E6 did not assess R1 for signs of injury related to the fall, such as inability to move limbs, unusual position of limbs or other areas of the body, or pain to a specific body part with movement. E8 stated, "The nurses wanted to send R1 out, but FM1 said they said they wanted them [Mobilex] to come in [to the facility] and do the x-ray because they didn't want R1 to go out to the hospital." During an interview on 12/22/22 at 12:01 PM with both FM1 and FM2, it was reported that FM1 arrived to visit R1 and discovered the resident on the floor disrobed from the waist down, incontinent of bowel and without an emergency pendant on 12/17/21. FM1 called for a nurse and E6 (LPN) was the nurse who arrived to assess R1. FM1 confirmed that E6 did not assess R1 for injury after the fall, took vital signs and asked whether R1 was in pain then poked a finger at R1's hip and R1 screamed in pain, E6 assisted R1 to the toilet, then to bed, and gave R1 pain medication. FM1 reported requesting an x-ray for R1 and that E6 agreed that the facility would order it. FM2 confirmed receiving a telephone call from E6 reporting R1's fall, FM2 then requested an x-ray at the facility, that hospice be notified and that R1 not be sent out to the hospital. Findings were reviewed during the exit conference on 2/21/22 at 3:15 PM with E1 (ED) AND E2 (DRC).		

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3225.0	**Regulations for Assisted Living Facilities**		
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Provider's Signature [signature], LNHA Title Executive Director Date 3/16/2022

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	mented. The accompanying risk management report documented FM2 as the responsible party notified, and that "FM1 and E8 (RCP) found the resident sitting on the floor. Resident complained of hip pain... This nurse assessed resident and discovered skin tear and obtained a treatment order from hospice." The incident report and accompanying documentation did not document assessment for injury related to the fall such as inability to move limbs, unusual position of limbs or other areas of the body, pain to a specific body part with movement, or immobilization of the resident due to possible injury. 12/17/21 9:37 PM– E6 (LPN) placed a call to hospice and reported R1's fall to the on-call service. 12/17/21 untimed– E3 (hospice RN) documented on a note, "On arrival patient is in bed resting comfortably. Arousable to voice. Alert and oriented...with periods of confusion. Denies pain. Clean, dry, intact dressing [to] the left forearm. Bed in low locked position... Reviewed fall precautions with facility staff. Instructed facility staff to call hospice with any questions or concerns". E3's note did not document an assessment for injury related to the fall as above. 12/18/21 untimed- E3 (hospice RN) documented in a note, "On arrival patient is sitting in wheelchair... alert and oriented...with periods of confusion. Required full assistance with standing and pivoting back to bed reported 10/10 right hip pain. Instructed facility staff to administer pain medication. Patient is able to bend the leg at the knee. Range of motion completed on		

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	right leg. Patient reports pain afterwards. Spoke with daughter with an update. Daughter does not want resident sent to an emergency room. Instructed daughter to call hospice with any questions or concerns." There were no documented instructions for immobilization of the resident due to possible injury. 12/19/21- R1's clinical record lacked evidence of a note or assessment documented by a nurse. 12/20/21 – A note in R1's clinical record documented, "Assessed resident this morning. Nurse aide reported resident with severe pain. Resident presented with external [unusual outward] rotation to the right foot. Attempted to lift right leg at this time resident stiffened up and complained of pain. E5 (NP) notified, new orders for x-ray of hip to be done today. Daughter called and is aware an x-ray will be done today." 12/20/21 untimed – E4 (hospice RN) documented in a note, "Patient received resting in bed. Complaint of pain in right hip. Facility staff states Mobilex has not arrived yet to complete x-ray. Patient was medicated at 11:30 [AM/PM unknown] with morphine. Nurse states medication... effective. Visit with patient stating no pain if she does not move. Attempted to move and yelled out in pain. This nurse provided incontinence care with careful turning. Placed cloth pad below for assist with transfers...conversations with family, patient, and E5 (NP). Check x-ray and manage pain for now." 12/20/21 4:31 PM – E5 (NP) documented a visit to R1 to follow up on chronic medical problems and fall assessment after a fall.		

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	Patient seen and examined at the bedside today. Patient with complaint of right hip and unable to perform ADL's (activities of daily living such as walking and toileting) or get out of bed related to the severity of the right hip pain. Pt stated wanting an x-ray to see what was wrong." 12/20/21- An order was written for R1 to have an x-ray of the right hip pain post (after) fall. Results of the x-ray were sent to the facility the same day at 7:10 PM and concluded a broken right hip. During an interview on 2/18/22 at 2:23 PM with E6 (LPN), E6 stated, "I don't recall much about the incident, whatever is there in the incident report is what was done." E6 then called the Surveyor again at 3:38 PM and stated, "R1 was on the floor, FM1, FM3 and R8 (RCP) were present and told me R1 fell. R1 had pain in the hip. I gave pain medication. The family did not want R1 sent to the hospital. I took vital signs and asked about pain. I got R1 cleaned up and put to bed." When asked if any additional assessment was done, such as injury and whether any immobilization precautions were put into place, E6 stated "I notified hospice to do that. Then FM2 the family on the chart but not the physician because we are to call hospice and they do the rest." E6 was unable to recall if R1 had on an alert pendant and whether the family asked for an x-ray to be completed at the facility. During an interview on 2/18/22 at 1:49 PM, E5 (NP) confirmed being made aware of R1's fall on 12/20/21 and that a visit was made that day that resulted in E5 ordering an x-ray for R1. E5 stated that FM2 was "My		

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	point of contact, when I called FM2 was adamant not to send R1 to the hospital." E5 did not confirm that FM2 refused an x-ray and stated, "They were resistant to a lot." During an interview on 2/21/22 at 1:43 PM with E2 (DRC) it was reported that all nursing staff was familiar with ordering x-rays using Mobilex and that the facility does not do monitoring for wearing of alert pendants. E2 reported x-rays were ordered "As needed if there's a fall and we suspect an injury, in R1's case the family didn't want her to go out." E2 was asked "Whether the family requested an x-ray at the facility?" E2 responded, "It was one person making the decisions. E5 (NP) can tell you, they [FM1 and FM2] weren't on the same page." FM1 and FM2 are listed as shared POA in R1's clinical record. During an interview on 2/21/22 at 2:38 PM, E4 (hospice RN) reported speaking with FM1 and FM2 "After the weekend" that R1 fell. E4 stated, "The decision was not to send R1 to the hospital. I think one of our nurses could see that it looked like a fracture, the foot was turned out and R1 was having some pain, so I think that the x-ray occurred, and the results came, I think that [x-ray] was done over the weekend." During an interview on 2/21/22 at 2:58 PM, E8 (RCP) confirmed that FM1 found R1 on the floor, incontinent of bowel, without the alert pendant. E8 stated, "Towards evening or late afternoon, I was the medication tech. R1 left the dining room and later E8 was told by FM1 that R1 was sitting on the floor. R1 didn't have an alert pendant on, we found the pendant hanging near the bed somewhere. I went and got E6 (LPN)... R1		

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	said "ouuuhh my hip hurts." E8 confirmed being present during E6's (LPN) assessment of R1. E8 stated, I was there when our nurse was there, E6 did vital signs and asked about pain and asked did they want R1 sent out, they said no." E8 confirmed during her time in the room, E6 did not assess R1 for signs of injury related to the fall, such as inability to move limbs, unusual position of limbs or other areas of the body, or pain to a specific body part with movement. E8 stated, "The nurses wanted to send R1 out, but FM1 said they said they wanted them [Mobilex] to come in [to the facility] and do the x-ray because they didn't want R1 to go out to the hospital." During an interview on 12/22/22 at 12:01 PM with both FM1 and FM2, it was reported that FM1 arrived to visit R1 and discovered the resident on the floor disrobed from the waist down, incontinent of bowel and without an emergency pendant on 12/17/21. FM1 called for a nurse and E6 (LPN) was the nurse who arrived to assess R1. FM1 confirmed that E6 did not assess R1 for injury after the fall, took vital signs and asked whether R1 was in pain then poked a finger at R1's hip and R1 screamed in pain, E6 assisted R1 to the toilet, then to bed, and gave R1 pain medication. FM1 reported requesting an x-ray for R1 and that E6 agreed that the facility would order it. FM2 confirmed receiving a telephone call from E6 reporting R1's fall, FM2 then requested an x-ray at the facility, that hospice be notified and that R1 not be sent out to the hospital. Findings were reviewed during the exit conference on 2/21/22 at 3:15 PM with E1 (ED) AND E2 (DRC).		